PRINTED: 09/09/2020 FORM APPROVED

## Division of Health Care Facilities

TN2101  B. WING C 08/18/2020  NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, SMITHVILLE  STREET ADDRESS, CITY, STATE, ZIP CODE 825 FISHER AVE P O BOX 549 SMITHVILLE, TN 37166	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X2) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  NHC HEALTHCARE, SMITHVILLE  825 FISHER AVE P O BOX 549  SMITHVILLE, TN 37166				5 11/11/0		1		
NHC HEALTHCARE, SMITHVILLE  825 FISHER AVE P O BOX 549  SMITHVILLE, TN 37166			TN2101	B. WING		08/1	8/2020	
NHC HEALTHCARE, SMITHVILLE SMITHVILLE, TN 37166								
SUMMARY STATEMENT OF DEFICIENCIES 15 DEPOVIDED'S DIAN OF CORRECTION 25	NHC HEALTHCARE. SMITHVILLE							
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI		(EACH DEFICIENC)			CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE	
N 000 Initial Comments N 000	N 000	Initial Comments		N 000				
Investigation of complaints #51125 and #51491 and an Infection Control Focused Survey were conducted on 8/18/2020 at NHC Smithville. No health deficiencies were cited in relation to the complaints under Chapter 1200-08-6, Standards for Nursing Homes.		Investigation of compl and an Infection Cont conducted on 8/18/20 health deficiencies we complaints under Cha	rol Focused Survey were 20 at NHC Smithville. No ere cited in relation to the					

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE